Client Living Environment and Stability Profile (CLESP)

Please complete for clients at Time 1 and Time 2.

Please fax completed instrument to: (916) 654-3178

County Client Number 0 1 2 3 4 5 6 7 8 9 A B C D E F G H I J K L MN O P Q R S T U V W X Y Z 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			Assessment Type O Intake O Mid-Treatment Discharge (mark one): O Planned O Unplanned O Left Service Area O Aged Out O Death O Other/Unknown CAFAS Scores:	
Stability Information	Runaway Informa		Role Performance:	0 10 20 30
Within the last six months, in how many places has this child lived for at least one week? (If unknown, please leave blank.) 1 2 3 4 5 6 7 8 9 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	How many times has the <u>LAST</u> 6 months? O None O Ty	this child run away within wo or More Times nknown cations ly taking any	School/Work Community Behavior Toward Others Mood/Self Harm: Moods/Emotions Self-Harmful Behavior Other: Substance Use Thinking	000000000000000000000000000000000000000
Living Situation			Current	Predominant
Please mark the bubble that corresponds to BOTH the <u>Current AND Predominant</u> (within the previous 6 months) Living Situation (mark one bubble for each situation). Incarcerated (CYA, Juvenile Hall, etc.)			Living Situation	Living Situation
Psychiatric Hospital			0	0
Group Home (Level 12-14)			0	0
Group Home (Level 10-11)			0	0
Group Home (Level 0-9)			0	0
Foster Care, Therapeutic Foster Care or Kinship Care			0	0
Living with Biological or Adoptive Family (Non-Foster Care)			0	0
Living Independently by Self, with Spouse, Roomate, and/or Dependent Children			0	0
Homeless / Homeless Shelter / Runaway Shelter				
For children living either <u>at home</u> or <u>in a foster care setting</u> , with whom does the child live? (Mark one bubble for each situation.)			O Current Living Situation	Predominant Living Situation
Both Birth Mother and Biological Father Single Birth Mother/Father			0	0
Birth Parent with Step or Long-Term Partner			0	Q
Grandparent Aunt/Uncle			0	0
Sibling			0	Ö
Non-Biological Foster Parent Other			<u> </u>	0
Unknown			0	0 /
	•			
Is the primary caregiver receive emotional needs of the child?			nem meet the	physical and
On the average, how often do		chool during a 5-day wo		
Current / Planned (if new) See Mark the category that describes the currently receiving, on average. —Outpatient (mark one):	services the client is	If applicable, please ider Scales Agency Worker I	Form was not co	mpleted:
O More than once a week O Once a week O Less than once a week O Day Treatment O Inpatient/24-Hour Services (e.g., have not seen child for 60 days or 10 to Complete (e.g., staff change)				
Child's Name:)		Draft

County Client #: _____ Date: ____